BEFORE THE KANSAS WORKERS COMPENSATION APPEALS BOARD

VIA CHRISTI HOSPITALS WICHITA, INC. Service Provider	)	
V.	)	
KAN-PAK, LLC Respondent	)	ARISING FROM THE WORKERS COMPENSATION
AND	)	CLAIM Docket No. 1,063,612
TRAVELERS INDEMNITY COMPANY OF AMERICA Insurance Carrier	)	
AND	)	
PARADIGM MANAGEMENT SERVICES, LLC	)	

ORDER

STATEMENT OF THE CASE

Via Christi Hospitals Wichita, Inc. (Via Christi) appealed the March 8, 2016, Order of the Hearing Officer (Order) entered by Hearing Officer Douglas A. Hager. The Board heard oral argument on July 22, 2016, in Wichita, Kansas. Edward D. Heath, Jr., of Wichita, Kansas, appeared for Via Christi. Douglas C. Hobbs of Wichita, Kansas, appeared for Paradigm Management Services, LLC (Paradigm). Kan-Pak, LLC, and Travelers Indemnity Company of America were not relevant parties to this matter and were not represented in this matter.

The record considered by the Board is the transcript of the February 25, 2015, formal hearing and exhibits thereto; the transcript of the January 6, 2015, deposition of Scott Goll and exhibit thereto; and the transcript of the December 12, 2014, deposition of Jean Sherlock and exhibit thereto. The parties' stipulations are listed in the Order.

ISSUE

This is a medical fee dispute arising from Docket No. 1,063,612 in which claimant, Darin J. Pinion, sustained a compensable workers compensation accident on June 28,

2011. Claimant received medical care at Via Christi in the total billed amount of $1,048,569. Paradigm contracted with Travelers to process and pay claimant's medical bills. Paradigm paid Via Christi $136,451.60 as calculated under the MS-DRG method of reimbursement found in Hospital/Inpatient Ground Rule 6 of the Kansas Department of Labor Workers Compensation Schedule of Medical Fees (fee schedule), effective January 1, 2011. The 2011 Hospital/Inpatient Ground Rule 6 (2011 Ground Rule 6) states:

> **STOP-LOSS METHOD:**
> a. PURPOSE AND APPLICATION: Stop-loss is an independent reimbursement methodology that will reimburse the hospital for unusually costly services rendered during treatment to an injured worker. No charge attributable to implantables or trauma activation fees shall be considered for purposes of determining eligibility for, and reimbursement under, stop-loss.
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> b. COMPUTATION OF THE MAXIMUM ALLOWABLE REIMBURSEMENT UNDER STOP-LOSS: To be eligible for the stop-loss payment, the total charges for the hospital inpatient stay, excluding charges attributable to implantables and trauma activation fees, must be at least Sixty Thousand Dollars ($60,000.00), the minimum stop-loss threshold. If the total charges for the hospital inpatient stay equal or exceed the minimum stop-loss threshold, the total charges are then multiplied by seventy percent (70%) to determine the maximum allowable reimbursement excluding implantables (see Ground Rule 6 of these Ground Rules)[ ]and trauma activation fees (see Ground Rule 8 of these Ground Rules). If the MS-DRG level of reimbursement exceeds the $60,000 stop-loss threshold, the facility shall be paid billed charges multiplied by seventy percent (70%) *or the MS-DRG level whichever is least*; all other rules apply to making this determination. (Disputed language is italicized.)

Via Christi asserted the fee schedule contained language regarding reimbursement that was not intended to be included and that resulted in a lower payment. Via Christi requested Paradigm pay an additional $595,975.37.

Via Christi brought the matter before the Division of Workers Compensation (Division). On March 8, 2016, Hearing Officer Hager entered an Order denying Via Christi's request for further payment. The Hearing Officer found he lacked the authority to declare 2011 Ground Rule 6 void. However, the Order clearly indicated that if the Hearing Officer had the authority to make such a determination, he would have voided 2011 Ground Rule 6.

Via Christi argues 2011 Ground Rule 6 is invalid because it: (1) conflicts with K.S.A. 44-510i and (2) did not receive the statutorily mandated considerations from the Director of Workers Compensation. Further, Via Christi argues the application and enforcement of 2011 Ground Rule 6 would be arbitrary and capricious. Via Christi requests the Board order Paradigm to pay Via Christi the remaining balance of $595,975.37.

Paradigm contends it relied upon the valid language of 2011 Ground Rule 6 when calculating its payment to Via Christi. Paradigm argues: (1) the procedure required to enact a valid regulation was followed; (2) the economic impact statement criterion was satisfied; (3) there is no conflict between the fee schedule and its enabling statute and (4) enforcement of the fee schedule, as written, is not arbitrary and capricious. Paradigm maintains its payment of $136,451.60 is the maximum allowable by law and Via Christi's request for further payment should be denied.

A key dispute is when the disputed language was placed in 2011 Ground Rule 6. Via Christi contends the disputed language was placed in 2011 Ground Rule 6 after the process to approve it was completed. Paradigm asserts there is no evidence of when the disputed language was inserted and, therefore, the disputed language very well may have been properly reviewed and approved.

The sole issue is whether the Hearing Officer has the authority to declare void 2011 Ground Rule 6.

FINDINGS OF FACT

After reviewing the entire record and considering the parties' arguments, the Board adopts the findings of fact contained in the Order and notes certain additional facts.

The disputed language in 2011 Ground Rule 6 is not in the 2010 fee schedule (Hospital/Inpatient Ground Rule 7) or 2012 fee schedule (Hospital/Inpatient Ground Rule 6).

At the beginning of the 2010, 2011 and 2012 fee schedules is a section setting forth the most important revisions in that year's fee schedule. The 2010 fee schedule lists as an important change that the previous Hospital/Ambulatory Surgical Center section was divided into two new sections, one of which was Hospital/Inpatient. The 2011 fee schedule does not mention the change in Ground Rule 6 as an important revision. The 2012 fee schedule stated the following was an important revision:

> 6. Ground Rule 6 of Hospital/Inpatient has been modified to remove the last sentence that stated["]If the MS-DRG level of reimbursement exceeds the $60,000 stop-loss threshold, the facility shall be paid billed charges multiplied by seventy percent (70%) or the MS-DRG level whichever is least; all other rules apply to making this determination."[1]

[1] Kansas Department of Labor, Workers Compensation Schedule of Medical Fees, effective January 1, 2012, at i.

Scott Goll, senior vice president of operations for Paradigm, testified that Travelers paid Paradigm $524,945. In turn, Paradigm agreed to pay all of claimant's medical expenses to Via Christi. Paradigm, based upon the 2011 fee schedule, expected to pay Via Christi $139,207.85. Mr. Goll indicated it did not strike him as odd that a medical bill of over $1,000,000 was written down to less than $140,000 and gave examples of California, Michigan, Texas and perhaps Illinois where such a reduction might take place.

Anne Haught served as the Acting Director of Workers Compensation from mid-January through sometime in April 2011. She was manager of medical services from April 2011 until September or October 2011, and Acting Director of Workers Compensation from September or October 2011 until one or two months later, when she became Director of Workers Compensation through sometime in November 2012.

Ms. Haught testified the words "or the MS-DRG level whichever is least" were mistakenly placed in 2011 Ground Rule 6. She did not know how the incorrect language came to be placed in 2011 Ground Rule 6. The details of her discovery are outlined in the Order.

Ms. Haught indicated the Division created the proposed fee schedule and had it reviewed by an advisory panel (created by K.S.A. 2011 Supp. 44-510i(d)) and the Director of Workers Compensation. She testified that sometime between January and March 2010, a meeting of the advisory panel was held to review the fee schedule. Undated minutes of that meeting, in part, stated:

> 2) Hospital Inpatient Reimbursement
>
> • The division will adopt the 2010 MS-DRG's, the conversion factors will most likely remain the same for next year, although there is potential that Peer Group 2 will be decreased to a conversion factor of $6800 rather than the $7000. . . .[2]

The advisory panel meeting minutes do not mention the stop-loss method of payment when hospital inpatient charges exceed $60,000. According to Ms. Haught, the advisory panel minutes contain nothing that suggests the advisory panel discussed modifying Ground Rule 6 to include the disputed language.

Following approval of the advisory panel, the 2011 fee schedule was sent to the National Council on Compensation Insurance (NCCI) for review and analysis. A written analysis concerning the economic impact of the proposed 2011 fee schedule was sent from NCCI to the Division on June 17, 2010. The analysis concerning the proposed

[2] F.H. Trans., Ex. 8 at 1.

hospital inpatient fee schedule is technical and somewhat difficult to understand. It references MS-DRG procedures in Peer 1[3] and 2 hospitals, but makes no mention of the stop-loss method of payment when hospital inpatient charges exceed $60,000. According to Ms. Haught, nothing in the NCCI analysis indicates the stop-loss language in the 2010 fee schedule was modified for 2011 to indicate reimbursement would be the lesser of 70 percent of the bill or the MS-DRG rate.

Ms. Haught indicated that after the review by the advisory panel and NCCI, the administrative regulation and fee schedule go through the regulatory process. She explained the administrative regulation is reviewed and approved by the Kansas Department of Administration (KDA). The administrative regulation and a copy of the fee schedule then go to the Kansas Attorney General (AG). The AG reviews and approves the administrative regulation. Ms. Haught did not know if the AG read the fee schedule.

After the administrative regulation and fee schedule have been processed by the KDA and AG, a hearing is held before the Joint Committee on Administrative Rules and Regulations (JCARR) where a representative of the Division testifies. On August 16, 2010, Dr. Terry Tracy, former Kansas Department of Labor (KDOL) medical administrator, testified before the JCARR concerning the 2011 fee schedule:

> Hospital in-patient charges will be paid according to 2010 MS-DRGs (Medicare Severity Diagnosis Related Groups) cost weights, times a variable conversion factor/modifier that is determined by the peer group of the facility. For hospital/in-patient charges exceeding $60,000, discounting any implantables or trauma activation fees, the hospital/in-patient charges will be paid at billed charges, less 15%.[4]

According to Ms. Haught, members of the JCARR had the administrative regulation and the economic impact statement at the August 16, 2010, hearing. Ms. Haught indicated Dr. Tracy erroneously testified the 2011 fee schedule called for a 15 percent reduction, when it should have been 30 percent.

The August 16, 2010, minutes of the JCARR hearing summarized Dr. Tracy's testimony and requested that the economic impact statement be revised before a public hearing was held. A copy of the 2011 fee schedule was not appended to the JCARR minutes.

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[3] Via Christi is a Peer 1 hospital.

[4] F.H. Trans., Ex. 11.

A public hearing was held on the 2011 fee schedule by the KDOL on October 1, 2010, at which time an economic impact statement was presented. The economic impact statement provides no insight on the issue at hand.

Ms. Haught acknowledged that K.S.A. 77-422 allowed an agency to make temporary regulations lasting up to 240 days without going through required procedures. Ms. Haught indicated the Division did not promulgate a temporary regulation to correct the mistake in 2011Ground Rule 6. Nor was any warning placed on the KDOL website indicating there was an error in 2011Ground Rule 6. She confirmed that the original, incorrect version of 2011 Ground Rule 6 was on the KDOL website through at least January 16, 2012.

Ms. Haught indicated that at some point after January 16, 2012, she and Dr. Tracy had the language in the 2011 Ground Rule 6 on the KDOL website changed to what should have been the correct version.

Dr. Tracy did not know why or how the disputed language was placed in 2011 Ground Rule 6. He did not know when the mistake in 2011 Ground Rule 6 was discovered, but it was sometime in 2011. He indicated he thought that once the 2011 medical fee schedule was published, the Division was "stuck with it."[5]

The Hearing Officer, for reasons set forth in his Order, concluded the aforementioned provision in 2011 Ground Rule 6 should be void, but that he lacked authority to declare it void.

PRINCIPLES OF LAW AND ANALYSIS

K.S.A. 2011 Supp. 44-510i states:

> **Medical benefits; appointment of medical administrator; maximum medical fee schedule; advisory panel.** (a) The director shall appoint, subject to the approval of the secretary, a specialist in health services delivery, who shall be referred to as the medical administrator. The medical administrator shall be a person licensed to practice medicine and surgery in this state and shall be in the unclassified service under the Kansas civil service act.
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> (b) The medical administrator, subject to the direction of the director, shall have the duty of overseeing the providing of health care services to employees in accordance with the provisions of the workers compensation act, including but not limited to:
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> (1) Preparing, with the assistance of the advisory panel, the fee schedule for health care services as set forth in this section;

[5] *Id.* at 158.

(2) developing, with the assistance of the advisory panel, the utilization review program for health care services as set forth in this section;

(3) developing a system for collecting and analyzing data on expenditures for health care services by each type of provider under the workers compensation act; and

(4) carrying out such other duties as may be delegated or directed by the director or secretary.

(c) The director shall prepare and adopt rules and regulations which establish a schedule of maximum fees for medical, surgical, hospital, dental, nursing, vocational rehabilitation or any other treatment or services provided or ordered by health care providers and rendered to employees under the workers compensation act and procedures for appeals and review of disputed charges or services rendered by health care providers under this section;

(1) The schedule of maximum fees shall be reasonable, shall promote health care cost containment and efficiency with respect to the workers compensation health care delivery system, and shall be sufficient to ensure availability of such reasonably necessary treatment, care and attendance to each injured employee to cure and relieve the employee from the effects of the injury. The schedule shall include provisions and review procedures for exceptional cases involving extraordinary medical procedures or circumstances and shall include costs and charges for medical records and testimony.

(2) In every case, all fees, transportation costs, charges under this section and all costs and charges for medical records and testimony shall be subject to approval by the director and shall be limited to such as are fair, reasonable and necessary. The schedule of maximum fees shall be revised as necessary at least every two years by the director to assure that the schedule is current, reasonable and fair.

(3) Any contract or any billing or charge which any health care provider, vocational rehabilitation service provider, hospital, person or institution enters into with or makes to any patient for services rendered in connection with injuries covered by the workers compensation act or the fee schedule adopted under this section, which is or may be in excess of or not in accordance with such act or fee schedule, is unlawful, void and unenforceable as a debt.

(d) There is hereby created an advisory panel to assist the director in establishing a schedule of maximum fees as required by this section. The panel shall consist of the commissioner of insurance and 11 members appointed as follows: One person shall be appointed by the Kansas medical society; one member shall be appointed by the Kansas association of osteopathic medicine; one member shall be appointed by the Kansas hospital association; one member shall be appointed by the Kansas chiropractic association; one member shall be appointed by the Kansas physical therapy association, one member shall be appointed by the Kansas

occupational therapy association and five members shall be appointed by the secretary. Of the members appointed by the secretary, two shall be representatives of employers recommended to the secretary by the Kansas chamber of commerce and industry; two shall be representatives of employees recommended to the secretary by the Kansas AFL-CIO; and one shall be a representative of providers of vocational rehabilitation services pursuant to K.S.A. 44-510g and amendments thereto. Each appointed member shall be appointed for a term of office of two years which shall commence on July 1 of the year of appointment. Members of the advisory panel attending meetings of the advisory panel, or attending a subcommittee of the advisory panel authorized by the advisory panel, shall be paid subsistence allowances, mileage and other expenses as provided in K.S.A. 75-3223 and amendments thereto.

(e) All fees and other charges paid for such treatment, care and attendance, including treatment, care and attendance provided by any health care provider, hospital or other entity providing health care services, shall not exceed the amounts prescribed by the schedule of maximum fees established under this section or the amounts authorized pursuant to the provisions and review procedures prescribed by the schedule for exceptional cases. With the exception of the rules and regulations established for the payment of selected hospital inpatient services under the diagnosis related group prospective payment system, a health care provider, hospital or other entity providing health care services shall be paid either such health care provider, hospital or other entity's usual and customary charge for the treatment, care and attendance or the maximum fees as set forth in the schedule, whichever is less. In reviewing and approving the schedule of maximum fees, the director shall consider the following:

(1) The levels of fees for similar treatment, care and attendance imposed by other health care programs or third-party payors in the locality in which such treatment or services are rendered;

(2) the impact upon cost to employers for providing a level of fees for treatment, care and attendance which will ensure the availability of treatment, care and attendance required for injured employees;

(3) the potential change in workers compensation insurance premiums or costs attributable to the level of treatment, care and attendance provided; and

(4) the financial impact of the schedule of maximum fees upon health care providers and health care facilities and its effect upon their ability to make available to employees such reasonably necessary treatment, care and attendance to each injured employee to cure and relieve the employee from the effects of the injury.

K.S.A. 44-510j, in part, states:

Medical benefits; fee disputes; utilization and peer review. When an employer's insurance carrier or a self-insured employer disputes all or a portion of a bill for services rendered for the care and treatment of an employee under this act, the following procedures apply:

(a)(1) The employer or carrier shall notify the service provider within 30 days of receipt of the bill of the specific reason for refusing payment or adjusting the bill. Such notice shall inform the service provider that additional information may be submitted with the bill and reconsideration of the bill may be requested. The provider shall send any request for reconsideration within 30 days of receiving written notice of the bill dispute. If the employer or carrier continues to dispute all or a portion of the bill after receiving additional information from the provider, the employer, carrier or provider may apply for an informal hearing before the director.

(2) If a provider sends a bill to such employer or carrier and receives no response within 30 days as allowed in subsection (a) and if a provider sends a second bill and receives no response within 60 days of the date the provider sent the first bill, the provider may apply for an informal hearing before the director.

(3) Payments shall not be delayed beyond 60 days for any amounts not in dispute. Acceptance by any provider of a payment amount which is less than the full amount charged for the services shall not affect the right to have a review of the claim for the outstanding or remaining amounts.

(b) The application for informal hearing shall include copies of the disputed bills, all correspondence concerning the bills and any additional written information the party deems appropriate. When anyone applies for an informal hearing before the director, copies of the application shall be sent to all parties to the dispute and the employee. Within 20 days of receiving the application for informal hearing, the other parties to the dispute shall send any additional written information deemed relevant to the dispute to the director.

(c) The director or the director's designee shall hold the informal hearing to hear and determine all disputes as to such bills and interest due thereon. Evidence in the informal hearing shall be limited to the written submissions of the parties. The informal hearing may be held by electronic means. Any employer, carrier or provider may personally appear in or be represented at the hearing. If the parties are unable to reach a settlement regarding the dispute, the officer hearing the dispute shall enter an order so stating.

(d) After the entry of the order indicating that the parties have not settled the dispute after the informal hearing, the director shall schedule a formal hearing.

(1) Prior to the date of the formal hearing, the director may conduct a utilization review concerning the disputed bill. The director shall develop and implement, or contract with a qualified entity to develop and implement, utilization review

procedures relating to the services rendered by providers and facilities, which services are paid for in whole or in part pursuant to the workers compensation act. The director may contract with one or more private foundations or organizations to provide utilization review of service providers pursuant to the workers compensation act. Such utilization review shall result in a report to the director indicating whether a provider improperly utilized or otherwise rendered or ordered unjustified treatment or services or that the fees for such treatment or services were excessive and a statement of the basis for the report's conclusions. After receiving the utilization review report, the director also may order a peer review. A copy of such reports shall be provided to all parties to the dispute at least 20 days prior to the formal hearing. No person shall be subject to civil liability for libel, slander or any other relevant tort cause of action by virtue of performing a peer or utilization review under contract with the director.

(2) The formal hearing shall be conducted by hearing officers, the medical administrator or both as appointed by the director. During the formal hearing parties to the dispute shall have the right to appear or be represented and may produce witnesses, including expert witnesses, and such other relevant evidence as may be otherwise allowed under the workers compensation act. If the director finds that a provider or facility has made excessive charges or provided or ordered unjustified treatment, services, hospitalization or visits, the provider or facility may, subject to the director's order, receive payment pursuant to this section from the carrier, employer or employee for the excessive fees or unjustified treatment, services, hospitalization or visits and such provider may be ordered to repay any fees or charges collected therefor. If it is determined after the formal hearing that a provider improperly utilized or otherwise rendered or ordered unjustified treatment or services or that the fees for such treatment or services were excessive, the director may provide a report to the licensing board of the service provider with full documentation of any such determination, except that no such report shall be provided until after judicial review if the order is appealed. Any decision rendered under this section may be reviewed by the workers compensation board. A party must file a notice of appeal within 10 days of the issuance of any decision under this section. The record on appeal shall be limited only to the evidence presented to the hearing officer. The decision of the director shall be affirmed unless the board determines that the decision was not supported by substantial competent evidence.

The 2011 version of K.A.R. 51-9-7, in pertinent part, states:

Fees for medical, surgical, hospital, dental, and nursing services, medical equipment, medical supplies, prescriptions, medical records, and medical testimony rendered pursuant to the Kansas workers compensation act shall be the lesser of the usual and customary charge of the health care provider, hospital, or other entity providing the health care services or the amount allowed by the “schedule of medical fees” published by the Kansas department of labor, dated January 1, 2011, and approved by the director of workers compensation on June 21, 2010, including

> the ground rules incorporated in the schedule and the appendices, which is hereby adopted by reference.

The outcome of this case will have a significant detrimental financial burden on the losing party. If Paradigm prevails, Via Christi will not be paid $595,975.37. If Via Christi prevails, Paradigm would be required to pay Via Christi a total of $732,426.97. That presumably would result in a loss for Paradigm of $207,481.97, the difference between $524,945 Paradigm was paid under its contract with Travelers and $732,426.97 Paradigm would have to pay Via Christi.

Based on the testimony of Ms. Haught and Dr. Tracy, Via Christi contends the disputed language was mistakenly inserted in 2011 Ground Rule 6 after the process to approve the 2011 fee schedule was completed. Via Christi argues that 2011 Ground Rule 6 is invalid and authority of the Board to order payment of the disputed medical expenses is inherent in K.S.A. 44-510j. At oral argument, Via Christi asserted the Hearing Officer and the Board have the right to resolve medical fee disputes between parties and that includes the authority to declare 2011 Ground Rule 6 invalid, because it mistakenly contained the erroneous language.

The Board has repeatedly ruled neither it, nor an administrative law judge (ALJ), has jurisdiction or authority to declare a regulation void.[6] In *Hall*,[7] a Board Member stated:

> There is no question the Director of Workers Compensation may adopt the rules and regulations that are necessary for administering the Workers Compensation Act. The Act provides:
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> > The director of workers compensation may adopt and promulgate such rules and regulations as the director deems necessary for the purposes of administering and enforcing the provisions of the workers compensation act. . . . All such rules and regulations shall be filed in the office of the secretary of state as provided by article 4 of chapter 77 of the Kansas Statutes Annotated and amendments thereto.[8]

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[6] *Hall v. Knoll Building Maintenance, Inc.*, No. 1,056,687, 2011 WL 6122930 (Kan. WCAB Nov. 29, 2011), *aff'd*, *Hall v. Knoll Building Maintenance, Inc.*, 48 Kan. App. 2d 145, 285 P.3d 383 (2012); *Gordon v. Allied Staffing, LLC*, No. 1,036,058, 2009 WL 607647 (Kan. WCAB Feb. 27, 2009); *Randel v. Leroy Perry d/b/a Perry Const.*, No. 251,165, 2008 WL 3280288 (Kan. WCAB July 31, 2008) and *Jones v. Tyson Fresh Meats, Inc.*, No. 1,030,753, 2008 WL 651673 (Kan. WCAB Feb. 27, 2008).

[7] *Hall*, *supra*.

[8] K.S.A. 44-573.

> And administrative regulations that are adopted pursuant to statutory authority for the purpose of carrying out the declared legislative policy have the force and effect of law.[9]
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> > 'Rules or regulations of an administrative agency, to be valid, must be within the statutory authority conferred upon the agency. Those rules or regulations that go beyond the authority authorized, which violate the statute, or are inconsistent with the statutory power of the agency have been found void. Administrative rules and regulations to be valid must be appropriate, reasonable and not inconsistent with the law.' *Pork Motel, Corp. v. Kansas Dept. of Health & Environment*, 234 Kan. 374, Syl. ¶ 1, 673 P.2d 1126 (1983).[10]
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> Because a regulation has the force and effect of law, such a regulation is as binding on the administrative agency as if it was a statute enacted by the legislature. Consequently, the Board concludes neither the ALJ nor the Board has jurisdiction and authority to determine that a regulation is void.

In *Acosta*,[11] the Kansas Supreme Court ruled the Board was without authority to declare Acosta's initial award void ab initio on the basis of fraud. National Beef argued administrative tribunals have the inherent power to do so when an award has been obtained by fraud. The Kansas Supreme Court disagreed, stating:

> Further, notwithstanding Larson's opinion regarding the inherent power of courts to set aside judgments procured by fraud, the fact remains the ALJ and the Board are both administrative bodies. "'Administrative agencies are creatures of statute and their power is dependent upon authorizing statutes, therefore any exercise of authority claimed by the agency must come from within the statutes. There is no general or common law power that can be exercised by an administrative agency.'" *Legislative Coordinating Council v. Stanley*, 264 Kan. 690, 706, 957 P.2d 379 (1998). Further, the Workers Compensation Act is substantial, complete, and exclusive, covering every phase of the right to compensation and of the procedure for obtaining it. See *Jones v. Continental Can Co.*, 260 Kan. 547, 557, 920 P.2d 939 (1996).
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> As noted above, the Workers Compensation Act provides an explicit procedure which allows an ALJ, on a motion for review and modification, to modify an award for fraud by increasing or diminishing the compensation. K.S.A.

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[9] See K.S.A. 77-425; *Vandever v. Kansas Dept. of Revenue*, 243 Kan. 693, Syl. ¶ 1, 763 P.2d 317 (1988); *Harder v. Kansas Comm'n on Civil Rights*, 225 Kan. 556, Syl. ¶ 1, 592 P.2d 456 (1979).

[10] *State v. Pierce*, 246 Kan. 183, 189, 787 P.2d 1189 (1990).

[11] *Acosta v. National Beef Packing Co.*, 273 Kan. 385, 44 P.3d 330 (2002).

> 44-528(a). Nothing in the statute allows the ALJ to declare the award void ab initio, and according to the general rule regarding review and modification, the modification operates only prospectively. See *Ferrell*, 223 Kan. at 423. Where there is a complete and legislated procedure, there is no room for the ALJ to invoke the "inherent power" of the tribunal to declare an award void ab initio for fraud.[12]

In *Russell*,[13] the Kansas Supreme Court stated:

> Errors plainly clerical in character, mere inadvertences of terminology, and other similar inaccuracies or deficiencies will be disregarded or corrected where the intention of the legislature is plain and unmistakable. But the court cannot delete vital provisions or supply vital omissions in a statute. No matter what the legislature may have really intended to do, *if it did not in fact do it, under any reasonable interpretation of the language used*, the defect is one which the legislature alone can correct.[14]
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> . . .
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> Courts frequently face the temptation to usurp legislative functions by writing into statutes something which the legislature itself did not put in them. But, however laudable the end sought may seem to be, the importance of observing the limitations of the judicial function transcends all immediate and temporary consideration. Vital defects in the statute are for the legislature to correct.[15]

The addition of the language, "or the MS-DRG level whichever is least," is not merely a clerical error. Ms. Haught and Dr. Tracy certainly believed the aforementioned language was mistakenly inserted in 2011 Ground Rule 6. The Hearing Officer believed 2011 Ground Rule 6 was invalid, but determined he had no authority to declare it so. The Board concurs. The duty and obligation to correct the alleged error in 2011 Ground Rule 6 lies with the Division. They modified the 2012 fee schedule to omit the disputed language. No provision of the Kansas Workers Compensation Act grants the Hearing Officer or the Board authority to declare a section of the medical fee schedule invalid or void.

The dissent argues K.S.A. 2011 Supp. 44-510i(c)(1) requires the Hearing Officer and Board to review the reasonableness of the application of the fee schedule. The

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[12] *Id.* at 396-97.

[13] *Russell v. Cogswell*, 151 Kan. 793, 101 P.2d 361 (1940).

[14] *Id.* at 795.

[15] *Id.* at 796-97.

majority disagrees with that analysis. As noted above, nothing in the Act, including K.S.A. 2011 Supp. 44-510i(c)(1), gives the Board or Hearing Officer authority to invalidate part of the fee schedule because it is deemed unreasonable. As noted in *Acosta*, there is no general or common law power that can be exercised by an administrative agency. Contrary to the dissent's commentary, the majority has not failed to review the record before us. Unlike the dissent, the majority is not inclined to disregard plainly worded administrative regulations or rules under the guise of "reasonableness."

CONCLUSION

The Hearing Officer and Board do not have the authority to void Hospital/Inpatient Ground Rule 6 of the Kansas Department of Labor Workers Compensation Schedule of Medical Fees, effective January 1, 2011.

As required by the Workers Compensation Act, all five members of the Board have considered the evidence and issues presented in this appeal.[16] Accordingly, the findings and conclusions set forth above reflect the majority's decision and the signatures below attest that this decision is that of the majority.

AWARD

WHEREFORE, the Board affirms the March 8, 2016, Order of the Hearing Officer entered by Hearing Officer Hager.

IT IS SO ORDERED.

Dated this ____ day of September, 2016.

BOARD MEMBER

BOARD MEMBER

BOARD MEMBER

[16] K.S.A. 2015 Supp. 44-555c(j).

CONCURRING OPINION

The undersigned Board Member concurs with the majority that the Board has no authority to void an administrative regulation. That task is the business of the Courts, not the Board.

The Board is therefore required to provide full force and effect to an administrative regulation that the preponderance of the evidence clearly establishes resulted from a mistake. This Board Member, therefore, agrees with the majority that the Board's lack of jurisdiction under these circumstances compels such a result, but the undersigned finds it troubling.

The dissent asserts the Board, as opposed to a Court of law, has the authority to declare an administrative regulation invalid, thus rendering it of no legal force and effect. That notion is unsupported by the statutes cited in the dissent, or any of the case law cited. The Board is an administrative agency and our authority is defined and limited by statute. There is no "common law" or inherent authority provided to the Board and the ALJs in the Act. The Workers Compensation Act does not provide the Board jurisdiction to declare either a statute, or an administrative regulation promulgated thereunder, invalid. The Act is complete and exclusive. Under the rationale of the dissent, an administrative regulation could be enforced or ignored based on the simple finding of an ALJ or the Board that it is "unreasonable."

BOARD MEMBER

DISSENT

The undersigned respectfully dissents from the majority conclusion that the Board is without authority to void this particular agency regulation. Rules and regulations of an administrative agency, to be valid, must be within the statutory authority conferred upon the agency. If they go beyond such statutory authority or are otherwise inconsistent with the law, the rules and regulations are void.[17] The Court in *Halford* noted, "[a]dministrative rules and regulations to be valid must be appropriate, reasonable and not inconsistent with the law."[18]

[17] *Peck v. University Residence Committee of Kansas State Univ.*, 248 Kan. 450, 462, 807 P.2d 652 (1991), citing *Halford v. City of Topeka*, 234 Kan. 934, 677 P.2d 975 (1984).

[18] *Halford v. City of Topeka*, 234 Kan. 934, 940, 677 P.2d 975 (1984), citing *Pork Motel, Corp. v. Kansas Dept. of Health & Environment*, 234 Kan. 374, 673 P.2d 1126 (1983).

The majority wrote, "[n]o provision of the Kansas Workers Compensation Act grants the Hearing Officer or the Board authority to declare a section of the medical fee schedule invalid or void." To the contrary, K.S.A. 2011 Supp. 44-510i(c)(1) states, in part, "[t]he schedule of maximum fees shall be reasonable . . . ." In fee dispute matters brought under K.S.A. 44-510j, the language of K.S.A. 2011 Supp. 44-510i(c)(1) requires the Hearing Officer and the Board to review the reasonableness of the application of the Fee Schedule and gives each the authority to invalidate or void the regulation if it is found to be unreasonable. There would be no reason for the legislature to place the reasonableness standard in the statute if they did not intend to give the trier of fact at the agency level the authority to disregard provisions of the Fee Schedule that are not reasonable.

If the application of 2011 Ground Rule 6 is not reasonable, it is subject to being invalidated based upon the evidence presented in the record. A ruling, by the Hearing Officer or the Board, that this provision of the regulation is invalid or void would apply only to the facts presented in this case, and would not permanently void the entire regulation, or even this section of the regulation. The same determination of reasonableness would be made in future cases involving this or any other provision of the Fee Schedule.

Because the Hearing Officer and the majority failed to review the record to determine if the application of 2011 Ground Rule 6 was reasonable, as required by K.S.A. 2011 Supp. 44-510i(c)(1), the matter should be remanded to the Hearing Officer to allow the statutorily mandated analysis of whether the regulation, as applied, is reasonable.

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